



Home Health Care Medicare Advantage Blue Cross Blue Shield of MI

October 23, 2008

Home Health Care Association



Blue Cross Blue Shield of MI Medicare Advantage Home Health Care Provider Agenda

Welcome and Introduction

Trish Hahnefeld, BCBSM with Rose Zidzik, BCBSM

Current Issues with Statuses

Mindy Lawrence and Curtis McFadden, PGBA

Roster Billing

Lydia Bean, BCBSM

Recoupments

Venus Pope, Manager, BCBSM

Voucher Overview

Mindy Lawrence / Curtis McFadden, PGBA

Questions and Answers

All



Blue Cross Blue Shield of MI Medicare Advantage

Welcome

Trish Hahnefeld, BCBSM



Current HHA Issues/Status



HHC 2007-2008 Crossover Claims

Issue:

CMS changed their HIPPS codes effective 1/1/08 resulting in the inability to select correct prices when the dates of service span from 2007 to 2008 on an episode of care.

There are 2,043 claims impacted by this issue causing incorrect Payments

Resolution:

Once the guidelines from CMS are received the outstanding claims will be reprocessed within 30 days.



Mapping Issue with TAC/OASIS Code

Issue:

Incorrect mapping of TAC codes. Based on the April 2008 CMS changes the addition of TAC codes in price selection was not recognized appropriately. This occurred from April 1, 2008 to May 31, 2008 resulting in 1,014 HHC claims.

Resolution:

We are currently restoring and adjusting both the hard copy and EDI claims.



Final Bill Processing with One Line

Issue:

Inability to display final bill line level detail data on the remittance advice. This information is necessary to identify the final bill and reconcile patient accounts.

Resolution:

A change has been initiated that will allow lines to be added to adjustments, which will result in all lines showing on the provider voucher. This will be implemented no later than 2nd Quarter 2009. All efforts will be made to improve this date. An interim manual process will be implemented to identify the final bill on the remittance in the remarks section.



Bill Types Ending in XX7 or XX8

Issue:

Providers are currently not able to submit claims electronically with bill types ending in XX7 or XX8 for Home Health Care Claims.

Resolution:

PGBA has initiated a change to allow these bill types to be submitted electronically.

Expected completion Date November 21, 2008



HHA Changes For 2008

- Significant Change in Care (SCIC) claims are no longer valid
- HIPPS Code now begin with a number instead of “H”
- Additional fields in the 2008 HHA Pricer: Source ADM Code, Recode IND, Episode Timing, and Severity Points
- (Oasis/TAC) codes are required
- Definition of LUPA Add-on: Contains four or less visits, the HIPPS code begins with 1 or 2, the admission date and the from date of service match, and the source of admission is not B or C
- Supply revenue codes billed after October 1, 2008 must have a corresponding HIPPS code



Claim Submission Tips

- The claim must contain provider information, patient information, CBSA, Type of Bill, Date of Service, Source of Admission and HIPPS code.
- The 18 digit OASIS / Treatment Authorization Code (TAC) is required.



Timeliness of HHC Claims for 2008

- 96.9% of HHC Claims were processed in less than 30 days
- 2.7% of HHC Claims were processed greater than 30 days
- 0.4% of HHC Claims were processed greater than 60 days



Roster Billing



Roster Billing

Overview of the Following Topics

- Flu and Pneumonia Vaccine Benefit, Coding and Allowance
- Roster Billing Information and Forms
- Problem Issues Identified and Resolved
- 2008-2009 Influenza Season Educational Resources



Roster Billing

Flu and Pneumonia Vaccine Benefit

- Influenza and PPV vaccines are covered Medicare Part B benefits. Coverage for these vaccines is provided under the member's BCBSM medical coverage.
- Coverage for vaccines such as influenza and pneumococcal for intermediate and high-risk patients is provided under Part B, which means it's a benefit under the Medicare Advantage private fee-for-service coverage. These services are usually provided in a physician's office or by mass immunizers.
- The vaccines should not be billed to the member's Medicare Part D prescription drug plan because they are not Part D covered drugs.



CPT Procedure Codes for Flu and Pneumococcal Vaccines

- **90655** Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
- **90656** Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
- **90657** Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use



CPT Procedure Codes for Flu and Pneumococcal Vaccines (cont.)

- **90658** Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
- **90660** Influenza virus vaccine, live, for intranasal use
- **90732** Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage for use in individuals 2 years or older, for subcutaneous or intramuscular use
- **G0008** Influenza vaccine administration
- **G0009** Pneumococcal vaccine administration



Roster Billing

Fees effective 10-01-2008 to 12-31-2008

Flu Vaccine Allowance

- 90655 - \$16.879
- 90656 - \$18.198
- 90657 - \$6.609
- 90658 - \$13.218
- 90660 - \$22.316

Pneumococcal Vaccine Allowance

- 90732 - \$32.703

Fees effective 01-01-2008 to 12-31-2008

Administration Codes

- G0008 - G0009 - \$21.96 Detroit
\$19.55 all other locations



Roster Billing

Roster Billing Guidelines

- Blue Cross Blue Shield of Michigan Medicare Advantage private fee-for-service plans provide full coverage for influenza and pneumococcal polysaccharide vaccines with no member copayment.
- Health care providers and suppliers already enrolled in the Medicare program may use their Medicare provider identification and national provider identifier numbers and follow the roster billing process as long as they provide the flu or pneumococcal vaccine to multiple members.



Roster Billing

Issues Identified and Resolved

- **2006** Co-pay taken for flu shot (90741) in error
- Resolved - Claims were reprocessed in July 2007

- **2007** Claims for flu shots pertaining to group plans were processed incorrectly taking a 10% co-insurance and in some cases copays
- Resolved – Reprocessing of claims began 09-22-08 and completed on 09-30-08
- Web-DENIS article: October 3-17, 2008



Roster Billing

Issues Identified and Resolved

Signature on file requirements:

For all institutional providers that roster bill from inpatient or outpatient departments, and for all other providers outside of the institutional setting that roster bill, a stamped “signature on file” qualifies as an actual signature on a roster claim form provided that the provider has a **signed authorization on file** to bill Medicare for services rendered. In this situation, the provider is not required to obtain the patient signature on the roster, but instead has the option of reporting “signature on file.”



Roster Billing

2008-2009 Influenza Season Educational Resources

- Drugs and Drug Plans - Roster Billing Information and Forms

http://www.bcbsm.com/ma/drugs_and_drug_plans.shtml

- Coding and Allowance

<http://www.cms.hhs.gov/CompetitiveAcquisforBios/>

- Immunizers' Question & Answer Guide to Medicare Coverage of Influenza and Pneumococcal Vaccinations
Steps to Promoting Wellness Adult Immunizations

http://www.cms.hhs.gov/AdultImmunizations/Downloads/0809flu_guidefinal.pdf



Refund Process



Refund Process

Based on feedback from Michigan providers, the refund process was reviewed and we have implemented improvements to make recoveries easier for our providers.

Solicited Refund Process

- Initial offset* letter will be generated advising that an offset has occurred. The letter will include key information that describes the patient, date of service, amount and reason for the refund request.
- An account receivable will be added to recoup the money from your next check.
- 90 and 120 day letter for unsatisfied offsets
- New process implemented 9-26-08

*A process that automatically recovers overpayments from a provider's future claims payment(s)



Refund Process

UNSOLICITED REFUND PROCESS

- Contact Medicare Advantage Provider Inquiry and an offset will be set up instead of sending in a check
- New process will be implemented 10-27-08



Refund Process

PROVIDER BENEFITS

- More accurate servicing information
- Maintain ability to appeal
- Expansion of refund reason codes
- Decrease check-writing cost
- Avoid duplicate refunds from occurring



Voucher Review



Voucher Review

Remittance Improvements

Short Term:

Immediate resolution on final bill detail

Long Term:

- All adjustments will be produced on the voucher
- Liability will be clearly defined
- Truncated fields will be corrected
- 835 and 837 will be in synch
- Patient ID field will be present



Questions and Answers

Thank you for Attending